Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: PHYSICIANS AMBULATORY SURGERY CENTER P.O. BOX 2101 SAN ANTONIO, TX 78297-2101	MFDR Tracking #: M4-09-4558-01 DWC Claim #: Injured Employee: Date of Injury:
Respondent Name and Box #: LIBERTY INSURANCE CORP. Rep Box # 28	Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Several attempts have been made to get correct payment for the claimant on date of service stated above. Enclosed is the billing history on this claim, it will show where four bills have been sent. There are three explanation of benefits enclosed for your review. Several calls have been made to customer service. Please review the attached documents...A verbal authorization was given...Authorization number 080310437S001002 and case number 14502 to the verification department."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $1,298.87
3. CMS 1500
4. EOB's
5. Operative Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "CPT 23120 is bundled into CPT 23415. The original bill enclosed does not have a modifier as required. The submission for Medical Dispute Resolution lists 23415 with Modifier 59; however, this code remains un-reimbursed for the following reason. The operative report enclosed documents that only 5mm of the clavicle was resected. According to the American Association of Orthopaedic Surgeons (Bulletin 2004), CPT 23415 should only be codes as a separate procedure if 1 cm of the clavicle is resected. Below is the correct coding guidelines for distal clavicle resection."

Principal Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
6/25/08	23415-SG-LT and 23120-SG-59-LT (See Calculations Below)	B291, D20, Z345, 42, Z710, U301, 18	1-7	$1298.87
Total /Due:				$1298.87

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective 12/30/07, set out the reimbursement guidelines.

1. Codes 23120-SG-29-LT and 23415-SG-LT for date of service 6/25/08, were denied/reduced reimbursement based upon "B291-This is a bundled or non covered procedure based on Medicare Guidelines; No separate payment allowed; Z345-Left side; Z710-The charge for this procedure exceeds the fee schedule allowance; U301-This item was reviewed on a previously submitted bill, or on this bill, with notification of decision issued to payor or provider (Duplicate Billed); and 18-Duplicate claim/service."
2. The Respondent stated that modifier "-59" was not submitted on the original bill. A review of the original CMS-1500 dated 7/1/08 did not have the modifier; however, the subsequent three bills dated 9/12/08, 10/6/08 and 12/17/08 did include the modifier with CPT code 23120.
3. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
4. The 6-25-08 operative report indicates the claimant underwent "Anterior-inferior decompressive acromioplasty, left shoulder; and Mumford resection, left distal clavicle." Per Rule 134.402, CPT code 23120-SG-59-LT is not global to 23415-SG-LT; therefore, reimbursement is recommended.
5. Per review of Box 32 on CMS-1500, zip code 78258 is located in Bexar County (Reasonable Charge Locality 07). The maximum reimbursement amount, under Rule §134.402, is determined by locality.
6. The Requestor billed CPT code 23415-SG-LT -. This procedure is in the ASC Payment Group of 5. Therefore, $689.09 X 213.3% = $1,469.83. The insurance carrier paid $905.88. The difference between amount due and paid equals $563.95.
7. The Requestor also billed CPT code 23120-SG-59-LT - . This procedure is in the ASC Payment Group of 5. Therefore, $689.09 X 213.3% = $1,469.83. This amount times 50% for the multiple procedure rule equals $734.92. The insurance carrier paid $0.00. The difference between amount due and paid equals $734.92.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §134.1
28 Texas Administrative Code §134.402 effective 12/30/07

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to **additional** reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$1298.87** plus applicable accrued interest per Division Rule §134.130, due within 30 days of receipt of this Order.

DECISION AND ORDER:

Authorized Signature

Elizabeth Pickle, RHIA
Medical Fee Dispute Resolution Officer

2/12/09
Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.